

CASE STUDY

PROVIDENCE ST. JOSEPH HOSPITAL

Increasing naloxone distribution and strengthening addiction referral pathways

Background

In 2026, Providence St. Joseph Hospital, a 463-bed not-for-profit Catholic hospital in Orange, Calif., built on already-existing overdose prevention and addiction treatment efforts through the AHA HRET [Bridge to Care](#) initiative.

Since 2022, through a California Bridge Program grant, the hospital has provided free naloxone kits to emergency department patients and inpatients at risk for opioid overdose. Frontline leaders also operated a substance use navigation program and a small outpatient medication-assisted treatment clinic intended to help patients continue addiction treatment after hospitalization.

Despite those services, emergency department naloxone distribution rates varied widely from month to month. Staff turnover disrupted education efforts around overdose prevention and addiction care workflows, and some clinicians remained unfamiliar or uncomfortable with approaches such as naloxone distribution and medication-assisted treatment practices.

As part of the Bridge to Care initiative, hospital leaders reviewed internal naloxone distribution data and identified inconsistent emergency department workflows as a key area for improvement. The team focused on strengthening naloxone distribution processes, reinforcing staff awareness and improving coordination with addiction treatment providers and community services.

Increasing naloxone distribution in the emergency department

For three consecutive months, behavioral health leaders, psychiatric clinicians and emergency department managers worked toward a goal of distributing naloxone kits to at least 50% of emergency department patients discharged with opioid-related diagnoses. A clinical pharmacist monitored monthly distribution rates while clinicians and managers worked to improve front-line awareness and make naloxone distribution easier during routine patient care.

Leaders said annual staff education sessions usually increased naloxone distribution rates for a short period; over time, however, clinicians became less likely to remember the program as other patient care demands competed for their attention.

To keep naloxone distribution visible during daily workflows, the team worked with emergency department managers to create reminder signage near clinician workstations. Leaders decided against placing large posters throughout the department and instead developed smaller reminders that clinicians could see while documenting in the electronic health record or preparing discharge instructions.

The hospital also expanded overdose prevention efforts into maternal health departments, where leaders had already begun building stronger substance use support processes for pregnant patients. Obstetrics teams received naloxone education, secure electronic health record messaging alerts, and easier access to naloxone kits in obstetrics triage areas, enabling nurses to more easily offer kits to patients during visits.

Reducing barriers to addiction referrals

Hospital leaders said addiction referral processes needed to fit into existing clinical workflows or clinicians would struggle to use them consistently during busy shifts.

Rather than relying entirely on formal consult orders, inpatient teams increasingly used secure messaging within the electronic health record to communicate about patients with substance use concerns in real time. This included communications with the Emergency Clinical Decision Unit (ECDU), consisting of a psychiatrist and several psychiatric nurse practitioners, for any prescription needs. Behavioral health leaders said the approach allowed addiction specialists, nurses and physicians to coordinate care more quickly during hospitalization and reduced delays caused by email exchanges or informal outreach.

The hospital also expanded direct outreach to community treatment organizations, including intensive outpatient programs, residential treatment providers and outpatient addiction clinics. Psychiatric nurse practitioners and behavioral health leaders contacted local organizations directly to explain available hospital services, coordinate referrals and identify where patients could receive ongoing treatment after discharge.

Leaders described stigma surrounding substance use disorder as another ongoing barrier. Some clinicians hesitated to discuss overdose education and naloxone distribution or lacked familiarity with newer addiction treatment practices, including changes that made medication-assisted treatment prescribing more accessible in recent years. Team members said visible physician champions, repeated education and ongoing conversations across departments helped gradually increase clinician comfort with addiction treatment and overdose prevention practices.

Early results and next steps

By spring 2026, emergency department naloxone distribution rates had improved. Leaders reported that clinicians distributed naloxone kits to approximately 68% of eligible emergency department patients during March 2026, exceeding the team's original goal.

The team also observed that hospital awareness events and staff education campaigns often coincided with temporary increases in naloxone distribution rates, suggesting that clinicians offered naloxone more consistently when overdose prevention remained highly visible across the hospital.

Although leaders had not yet collected formal long-term outcome data, they said the work strengthened communication between emergency department clinicians, behavioral health teams and community treatment providers. The organization also planned to continue expanding referral relationships with community addiction programs and reinforcing staff awareness of overdose prevention and addiction treatment resources across the hospital.

This case study was supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services as part of a financial assistance award totaling \$910,000 with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. government.